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(To be filled out by parents of children and adolescents)

Please return with accompanying paperwork at or before first visit.

Name o	of Child			Today's date
Sex	Date of Birth	Age	Race	
School	attendending		Grade	
Mother (biological/adoptive)			Occupation	Yrs of education
Addres	S		Home phone	Work phone
Father	(biological/adoptive)		Occupation	Yrs of Education
(Addre	ss		Home phone)Work phone
If your	child is adopted, age of chi	ld when adop	ted	
Steptatl	her/Stepmother		Occupation	Yrs of education
If pare		your child wh	en parents began living a	?separated?widowed?part?Please describe
	y other adults who live in the	ne home:		
			-	
	list other children in the ho			
			Relationship	
Name_		Age	Relationship	
Name_		Age	Relationship	
	hild has brothers or sisters			e list:Age
				-
Name_		_		
mail an	d visits):			n the child (either in person or by
Grandp	parent(s)		Location	on
Grandp	parents(s)		Locati	on

Please describe your goal in making this appointment.				
When did the problem(s) begin?				
List anything you did to improve the problem				
PRENATAL HISTORY Were there any significant problems(medical, emotional) during the pregnancy? Yes No If so, please specify				
Were alcohol, medications, and/or other drugs used?				
Medications during labor and delivery:				
NEONATAL HISTORY Birthweight: Were there any significant problems for the child at birth or in the newborn phase? YesNo Please specify				
INFANCY (0 to 12 months) Check if applicable, any significant problems, delays, and/or difficulties your child had in the lst year: feedingsleepingbreathingcolicbowel/urinary habitsnot liking affectioncrawlinginability to be consoledsitting on ownemotional responsiveness Please specify any other significant problems during this period:				
Who cared for child during the first year?				

TODDLERHOOD (12 to 36 month			
Check if applicable, any significant p	problems, delays, and/o		
walking severe temper tantrums	feeding self		rst words
severe temper tantrums	using sentences		ntertaining self
self destructive behavior	toilet training	0	veractivity
stranger anxiety			
Please specify any other significant p	problems:		
Did your child attend daycare?ye	es no. If so at what	ages?	
Did your child attend preschool?	yesno. If so at wha	at ages?	
CHILDHOOD (3 to 11 years old)			
Check if applicable, any significant	problems, delays, and/o	or difficulties:	
impulsive	-	_reading skills	
nervous/fearful		_writing skills	
severe temper tantrums		_math skills	
destroying property		_school failure	
self-destructive habits		_completing tasks	
overactivity		_cooperating in grou	p activities
obeying		_very shy	-
bowel/urinary habits		_aggressive	
prolonged sadness or irritabilit	ty	_trouble sleeping	
Dlagg specify any other significant	nrohlama		
Please specify any other significant p	problems:		
ADOLESCENCE (12 to 18 years of Check if applicable, any significant prolonged sadness or irritability gang membership academic failure drug and alcohol use temper outbursts	problems, delays, and/o ty 	_truancy _aggressive _impulsive _sexually active _fighting	running awaycigarette smoking
Please specify any other significant p	problems:		
MEDICAL/HEALTH HISTORY			
Check if applicable any of the follow	ving health problems vo	our child has had:	
	hes or skin problems	meningitis	seizures
	uble with eyes/vision	asthma	high fevers
	uble with ears/hearing	bowel prob	
	ious injuries*	allergies*	anemia
lead poisoninghea	art problems	kidney pro	
	ld physical or sexual at		
*Please give details:			
List medications used over several r			
Primary Care Physician or Pediatrici	an and other treating m	nedical doctors (e.g.,	psychiatrists):

SOCIAL HISTORY Were/are both parents involved in the child's care?_____ Who stays with the child when the child is ill? Does your child require much scolding or discipline?_____ Please explain.___ What forms of discipline/guidance do you use?_____ What is your child's reaction to discipline/guidance?_____ Do parents usually agree on discipline/guidance? If no, please explain._______ Do you have extended family or friends in the community to help with the child? Describe._____ Does the child have a close relationship with an adult not presently living at home? What activities does the child do when not in school? Who watches your child after school hours?_____ Does the child play outside in the neighborhood?_____ How does the child get along with others (family, neighbors, peers)? What activities does the family do together?_____ What kinds of jobs or household responsibilities does your child have?_____ Does he/she do them willingly?_____Without prompting?____

Have there been any important changes in the family during the last year (examples: job changes, moves, births, deaths, separation or divorce)?
Does your child have any habits which concern you (nail-biting, bedwetting, drugs, truancy, etc.)?
Educational History
Are you satisfied with your child's progress in school?
What are his/her typical grades?
What does your child say about school?
Does your child receive (or has he/she in the past) any resource or special educational services ?
Please describe these and during what grades
Has your child ever received special services or been hospitalized for behavioral or emotional reasons? Please explain (and provide records)
Please list the names and addresses of any doctors, psychologists, speech therapists, or other professionals who have evaluated your child. (Please provide records of evaluations.)
At this stage of your child's development, what pleases you about him/her? What do you see as your child's strengths? (mental, social, physical, and emotional)

If you would care to, please discuss your aspirations for this childwhat you hope or expect h	nim/her to
pecome as an adult.	
ease feel free to add any information you feel will add to my understanding of your child.	